Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THE METHODIST HOSPITAL
P O BOX 1866
FORT WORTH TX 76101

Respondent Name

CITY OF HOUSTON

Carrier's Austin Representative Box

Box Number 29

MFDR Tracking Number

M4-11-4156-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I calculated the bill with the PC Pricer and show that it should pay 35545.45 X 143%=50829.99. Insurance paid 48046.18, which I show to be underpaid by 2783.81. I sent in a reconsideration with a copy of the PC Pricer I used to calculate bill and it was still denied. I requested documentation on how they calculated the bill but no information was provided."

Amount in Dispute: $2,783.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this dispute.

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2010 Through October 4, 2010	Inpatient Hospital Surgical Services	$2,783.81	$2,783.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section,

regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 21, 2011
   - 222 –Charge exceeds Fee Schedule allowance.
   - 993 –Reduction is based on the Inpatient Fee Schedule.
   - NFR –This bill indicates IMO Nurse Fee Review.
   - W1 –Workers Compensation State Fee Schedule Adjustment.

   Explanation of benefits dated April 29, 2011
   - 193 –Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W1 –Workers Compensation State Fee Schedule Adjustment..

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. No documentation was found to support a contractual agreement between the parties to this dispute. Therefore, the Division concludes that the disputed services are not included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).

4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 463 is $35,545.45.

   This amount multiplied by 143% is $50,829.99.

   The total maximum allowable reimbursement (MAR) is $50,829.99.

   This amount less the amount previously paid by the respondent of $48,046.18 leaves an amount due to the requestor of $2,783.81.

   The Division concludes that the requestor is entitled to $2,783.81 additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,783.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,783.81 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 23, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.